

STATE OF COLORADO



Authorization to Release Information

By signing this form, I understand that I am allowing the agency to obtain records from financial institutions, past and present employers, physicians, healthcare providers, hospitals, schools, and loan companies in order to provide documentation or verify information I have given to the agency. I am also allowing the agency to receive documentation and information from other persons or agencies not previously mentioned. I release these persons, agencies, or institutions from all liability for supplying such information pertaining to me or members of my household.

Please list below all household members who are receiving or applying for assistance.

_____	_____
_____	_____
_____	_____
_____	_____

Signature of Applicant

Date

Printed Name of Applicant

Signature of Applicant

Date

Printed Name of Applicant